Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

John Taylor, D.C.
c/o Pain & Recovery Clinic of North Houston
6660 Airline Dr.
Houston, TX 77076

MFDR Tracking #: M4-08-1637-01

Respondent Name and Box #:

Gray Insurance Co Inc
Rep. Box #: 19

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOC

Requestor's Position Summary: "Our facility has billed this service accordingly. It is NOT part of or included in another service or procedure."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $63.78
3. CMS 1500s
4. EOBs
5. Letter of Preauthorization Dated 05/09/07 for PT lumbar 3x week x 2 weeks for 6 sessions (6245432 F 1)

Sent
DEC 18 2007
TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "This fee dispute concerns an amount of $63.78 for CPT Code 97140."

Principal Documentation:

1. Response to DWC 60

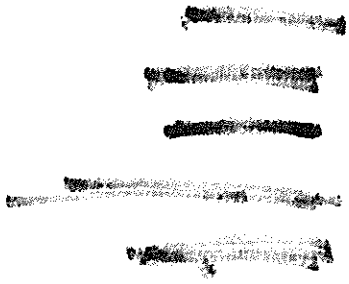
PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
05/19/07	97140	97	1 - 4	$63.78
Total Due:				$63.78

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "97 – Payment is included in the allowance of another service/procedure."
2. Per §134.202, CPT code 97140 is not global to the other CPT codes billed on same day (97110, 97112, and 97032).
3. CPT code 97140 has a MAR of $31.89 ($25.51 x 125%) x 2 units = $63.78 per §134.202.
4. Per review of Box 32 on CMS-1500, zip code 77076 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.



PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $63.78 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

[redacted]	[redacted]	12/18/07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.